

CERTIFICATE OF DEATH

10827

Reg. Dist. No.

10843

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>	
c. LENGTH OF STAY IN lb <u>44 yrs</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Joseph J. Figg</u>		4. DATE OF DEATH Month Day Year <u>September 16 1959</u>	
5. SEX <u>male</u>	6. COLOR OF RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 30 - 1915</u>
9. AGE (In years last birthday) <u>44</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Snow Hill, md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>L. Columbus Figg</u>		14. MOTHER'S MAIDEN NAME <u>Mattie Jane Lynch</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-12-504</u>	
17. INFORMANT <u>Ms Julia E. Figg, Snow Hill, md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1945</u> , 19 <u> </u> , to <u>Sept 16</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sept 15</u> , 19 <u>59</u> , and that death occurred at <u>4:00 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Snow Hill md</u>			
ACTUAL SIGNATURE <u>Jane Cohen</u> M.D.			
PHYSICIAN'S NAME (Type) <u>May E. Ginn</u>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Sept 19/59</u>	<u>Bates Methodist</u>	<u>Snow Hill md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>May E. Ginn</u>		ADDRESS <u>Snow Hill md</u>	
24a. REC'D BY REGISTRAR DATE <u>SEP 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Farris</u>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13401

1941-1942

13401

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page. The text appears to be organized into several paragraphs.]

CERTIFICATE OF DEATH

Reg. Dist. No.

10842

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City		c. LENGTH OF STAY IN 1b 5 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 614 Clarke Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LEMUEL Middle A. Last GODWIN		4. DATE OF DEATH Month September Day 15 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 29, 1875
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months 84 Days 84 Hours 84 Min. 84	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME SAMUEL GODWIN		14. MOTHER'S MAIDEN NAME CHASE.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs Alice Godwin, Pocomoke City, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ca of Prostate DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) 177X DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ① Exhaustion & Dehydration ② Electrolyte Imbalance		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-5- , 19 57 , to 9-15- , 19 59 , that I last saw the deceased alive on 9-15-59 , 19 59 , and that death occurred at 5:00 P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Cecil A. Duverney M.D.		ADDRESS (Street, city or town) state 801 - 4th St, Pocomoke	
PHYSICIAN'S NAME (Type) Cecil A. Duverney, M. D.		DATE SIGNED 9/15/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-19-59	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or county) (State) Prince George County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur A. Stalder		ADDRESS 254 Carroll St N.W. D.C.	
24a. REC'D BY REGISTRAR SEP 21 '59		24b. REGISTRAR'S SIGNATURE Arthur A. Stalder	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH		PLACE OF DEATH	
TIME OF DEATH		CAUSE OF DEATH	
AGE		SEX	
RACE		EDUCATION	
OCCUPATION		MARRIAGE	
BIRTH		DEATH	
FATHER		MOTHER	
SISTER		BROTHER	
CHILDREN		GRANDCHILDREN	
PARENTS		SIBLINGS	
RELATIVES		FRIENDS	
NEIGHBORS		CLERGY	
MEDICAL		NURSING	
PHARMACY		HOSPITAL	
LABORATORY		CORONER	
JURY		JUDGE	
PROSECUTOR		DEFENSE	
WITNESSES		SIGNATURES	
NOTARY		REMARKS	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10829

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Connecticut b. COUNTY New Haven			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City		c. LENGTH OF STAY IN 1b minutes		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Meriden 45 X-3			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Rt. 13				d. STREET ADDRESS 28 Morgan Street			
3. NAME OF DECEASED (Type or print) First Middle Last ELMER JACOB HOOPENGARNER				4. DATE OF DEATH Month Day Year September 27 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 27, 1894	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chef				10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) Ohio	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unk		16. SOCIAL SECURITY NO. 330-18-6856		17. INFORMANT Address 28 Morgan St. Meriden, Conn.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Obstruction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost, DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) He can lift the right arm, cannot lift the left arm and cannot walk							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>					
20a. TIME OF INJURY Month, Day, Year 9-27-59		20b. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20c. PLACE OF INJURY (Home, farm, factory, street, office, building, etc.) Worcester, Mass.		20d. (City or town) (County) (State) Worcester Mass	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE N. E. Sartorius, Sr.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) N. E. SARTORIUS, SR.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 9/28/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-2-59		22c. NAME OF CEMETERY Walnut Grove		22d. LOCATION (City, town, or county) (State) Meriden, Connecticut	
23. FUNERAL DIRECTOR'S SIGNATURE Henry H. Watson				ADDRESS Pocomoke City, Md.		24a. REC'D BY REGISTRAR DATE SEP 30 '59	
24b. REGISTRAR'S SIGNATURE Arthur J. Kneass							

NOTES
10/10/1911

10844

MASSACHUSETTS STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Locust Street
Connecticut
New Haven

Locust Street
minutes
Held at

U. S. R. 13
25 North Street

Simon
JACOB BROTHMAN
25 North Street

Age
40 years 07.10.04

Chief
Restaurant
Ohio

Edmond
Unknown

25 North Street
Caroline Brothman, Northern, Conn.

Caroline Brothman

Edmond
25 North Street
Northern, Connecticut

25 North Street
Northern, Connecticut

10845

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OCEAN CITY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OCEAN CITY</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>PHILA. AVE</u>	
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>MILLER</u> Last <u>MILLER</u>		4. DATE OF DEATH Month <u>SEPT</u> Day <u>30</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Approx. <u>67</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>POLICE (RETIRED)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CITY</u>	
11. BIRTHPLACE (State or foreign country) <u>PHILADELPHIA PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HARRY MILLER</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>MRS. HARRY MILLER</u>		Address <u>OCEAN CITY MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> 153.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>adenocarcinoma of colon (dex.)</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>2 mos.</u> <u>8 mos.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan.</u> 19 <u>59</u> to <u>Oct. 1</u> 19 <u>59</u> , that I last saw the deceased alive on <u>Sept. 29</u> 19 <u>59</u> and that death occurred at <u>6:00</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert G. Grath</u> M.D.		ADDRESS (Street, city or town, state) <u>BERLIN, MD.</u> DATE SIGNED <u>10/3/59</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT A. GRATH M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>OCT 3, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>	22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Burlage Inc. Home, Berlin, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE OCT 6 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur & Thomas</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1900

10830

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, MASS.

<p>NAME OF DECEASED</p>		<p>AGE</p>	
<p>SEX</p>		<p>DATE OF BIRTH</p>	
<p>PLACE OF BIRTH</p>		<p>DATE OF DEATH</p>	
<p>CAUSE OF DEATH</p>		<p>PLACE OF DEATH</p>	
<p>DATE OF INTERMENT</p>		<p>PLACE OF INTERMENT</p>	
<p>SIGNATURE OF PHYSICIAN</p>		<p>SIGNATURE OF REGISTRAR</p>	
<p>DATE OF SIGNATURE</p>		<p>DATE OF SIGNATURE</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10831

Reg. Dist. No.

10846

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Showell		c. LENGTH OF STAY IN 1b 6 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Showell			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) XX				d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Maurice Middle Roscoe Last Stuller				4. DATE OF DEATH Month Sept. Day 13 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 15, 1891		9. AGE (In years for birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COOK		10b. KIND OF BUSINESS OR INDUSTRY Short order		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John S. Stuller				14. MOTHER'S MAIDEN NAME Annie M. Nelson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) World War # 1		16. SOCIAL SECURITY NO. 216-07-9713		17. INFORMANT J. H. Stuller Address Showell, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Cerebral Hemorrhage sec 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis Generalized. (c) Arteriosclerosis Heart Muscle PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension, signs of Cerebral Hemorrhage 1947						INTERVAL BETWEEN ONSET AND DEATH 12 yrs 2 yrs	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Herman A Robbins M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) HERMAN A Robbins MD				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/16/59		22c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery		22d. LOCATION (City, town, or county) (State) Uniontown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar A. Kelly				24a. REC'D BY REGISTRAR SEP 17 '59		24b. REGISTRAR'S SIGNATURE Edgar A. Kelly	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF TEXAS
COUNTY OF DALLAS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10832

Reg. Dist. No.

10847

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Del</u> b. COUNTY <u>Sussex</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City, Del</u>		c. LENGTH OF STAY IN 1b <u>Week</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS <u>Monroe St</u>	
3. NAME OF DECEASED (Type or print) <u>Robert</u> First <u>Wooters</u> Middle <u>Wooters</u> Last		4. DATE OF DEATH Month <u>9</u> Day <u>27</u> Year <u>1957</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 28th 1885</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Miller - laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gasfit Mfg</u>	
11. BIRTHPLACE (State or foreign country) <u>Blades Del</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Wooters</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Ringer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Not</u>		16. SOCIAL SECURITY NO. <u>227-07-140</u>	
17. INFORMANT <u>Henry Hammond</u> Address <u>Ocean City, Del</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Obstruction</u> 430.1 DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden death</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Hypertension</u> DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hemiplegia - 9 yrs ago</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>No injury</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>N.E. Sartorius Sr</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>N.E. Sartorius Sr</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/30/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Red Men's Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Blades Del</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ronald Janner</u>		ADDRESS <u>Wilmington - Del.</u>	
24a. REC'D BY REGISTRAR DATE <u>OCT 1 '57</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thoma</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is anticipated, the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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WILLIAM H. HARRIS - BIRTHDAY - 10003
HARRIS WILLIAM H. - BIRTHDAY - 10003

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